

Schedule of Benefits

Employer: The City of Seattle

ASC: 100290

Issue Date: October 6, 2017

Effective Date: January 1, 2017

Schedule: 4A

Booklet Base: 4

For: Open Choice (PPO Medical) - S.P.O.G. Traditional Plan

PPO Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	Other Health Care
Calendar Year Deductible*			
<i>Individual Deductible*</i>	\$100	\$150	\$100
<i>Family Deductible*</i>	\$300	\$450	\$300

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

<i>Common Accident Deductible</i>	\$100	\$150	\$100
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Plan Payment Limit excludes plan copayments

Individual Payment Limit:

- For **network** expenses: \$400.
- For **out-of-network** expenses: \$1,600.

<i>Lifetime Maximum Benefit Per Person</i>	Unlimited	Unlimited	Unlimited
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Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network and other health care, unless specifically stated otherwise.

Note: Charges incurred for preventive care exams and tests, including routine physical exams, well child exams, routine eye exams, routine hearing exams and routine cancer screenings are not covered expenses, except as specifically provided below and in the *What the Plan Covers* section of your Booklet.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Routine Cancer Screenings</i>			
<i>Routine Mammography</i>	80% per test after Calendar Year deductible	60% per test after Calendar Year deductible	80% per test after Calendar Year deductible
Maximum tests per Calendar Year	1 test	1 test	1 test
<i>Family Planning Services - Other</i>			
Voluntary Sterilization for Males			
Outpatient	80% per visit after Calendar Year deductible.	60% per visit after Calendar Year deductible.	80% per visit after Calendar Year deductible.
Voluntary Termination of Pregnancy			
Outpatient	80% per visit after Calendar Year deductible.	60% per visit after Calendar Year deductible.	80% per visit after Calendar Year deductible.
<i>Family Planning Services</i>			
Female Contraceptive Counseling Services - Office Visits.	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit Calendar Year deductible
<i>Family Planning Services - Female Voluntary Sterilization</i>			
<i>Inpatient</i>	80% per visit after Calendar Year deductible.	60% per visit after Calendar Year deductible.	80% per visit after Calendar Year deductible.
<i>Outpatient</i>	80% per visit after Calendar Year deductible.	60% per visit after Calendar Year deductible.	80% per visit after Calendar Year deductible.
Hearing Aids	80% per visit	80% per visit	80% per visit
	No Calendar Year deductible applies.	No Calendar Year deductible applies.	No Calendar Year deductible applies.
Hearing Supply Maximum per 36 month period	\$1,000	\$1,000	\$1,000

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Physician Services			
Physician Office Visits (non-surgical)	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
Specialist Office Visits	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

Physician Office Visits-Surgery	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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Walk-In Clinic Non-Emergency Visit	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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Physician Services for Inpatient Facility and Hospital Visits	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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Administration of Anesthesia	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible
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Prenatal Visits	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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Emergency Medical Services			
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Hospital Emergency Facility and Physician	80% after Calendar Year deductible	Paid the same as the Network level of benefits.	Paid the same as the Network level of benefits.
	Emergency physician may not be a network provider. See Important Note below	See Important Note Below	See Important Note Below

Important Note: Out-of-network providers do not have a contract with **Aetna**, and may not accept payment of your cost share (your **deductible** and **payment percentage**), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or physician bills you for an amount above your cost share, you are not responsible for paying that amount. Please send us the bill at the address listed on the back of your member ID card and we will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.

Non-Emergency Care in a Hospital Emergency Room	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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<i>Urgent Care Services</i>			
<i>Urgent Medical Care</i> <i>(at a non-hospital free standing facility)</i>	\$35 copay per visit then the plan pays 100%	60% per visit after Calendar Year deductible	\$35 deductible per visit then the plan pays 80%
	No Calendar Year deductible applies.		No Calendar Year deductible applies.

<i>Urgent Medical Care</i> <i>(from other than a non-hospital free standing facility)</i>	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.
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Important Notice

A separate **urgent care deductible** or **copay** applies for each visit to an **urgent care provider** for **urgent care**.

Covered expenses that are applied to the **urgent care deductible** or **copay** cannot be applied to any other **deductible** or **copay** under your plan. Likewise, covered expenses that are applied to your plan's other **deductibles** or **copays** cannot be applied to the **urgent care deductible** or **copay**.

PLAN FEATURES

Outpatient Diagnostic and Preoperative Testing

<i>Complex Imaging Services</i>			
<i>Complex Imaging</i>	80% per test after Calendar Year deductible	60% per test after Calendar Year deductible	80% per test after Calendar Year deductible

<i>Diagnostic Laboratory Testing</i>			
<i>Diagnostic Laboratory Testing</i>	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible

<i>Diagnostic X-Rays</i>			
<i>Diagnostic X-Rays</i>	80% per procedure after Calendar Year deductible	60% per procedure after Calendar Year deductible	80% per procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Outpatient Surgery</i>			
<i>Outpatient Surgery</i>	80% per visit/surgical procedure after Calendar Year deductible	60% per visit/surgical procedure after Calendar Year deductible	80% per visit/surgical procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Inpatient Facility Expenses</i>			
<i>Birthing Center</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Hospital Facility Expenses</i> Room and Board (including maternity)	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
<i>Skilled Nursing Inpatient Facility</i>	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Maximum Days per Calendar Year	90 days	90 days	90 days
PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Specialty Benefits</i>			
<i>Home Health Care (Outpatient)</i>	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible	90% per visit after Calendar Year deductible
Maximum Visits per Calendar Year	130	130	130
<i>Skilled Nursing Care (Outpatient)</i>	90% per visit after the Calendar Year deductible	90% per visit after the Calendar Year deductible	90% per visit after the Calendar Year deductible
<i>Private Duty Nursing (Outpatient)</i>	90% per visit after the Calendar Year deductible	90% per visit after the Calendar Year deductible	90% per visit after the Calendar Year deductible

<i>Hospice Benefits</i>			
<i>Hospice Care –Facility Expenses</i> (Room & Board)	90% per admission after the Calendar Year deductible	90% per admission after the Calendar Year deductible	90% per admission after the Calendar Year deductible
<i>Hospice Care – Other Expenses during a stay</i>	90% per admission after the Calendar Year deductible	90% per admission after the Calendar Year deductible	90% per admission after the Calendar Year deductible
Maximum Benefit per lifetime	Unlimited days	Unlimited days	Unlimited days

<i>Hospice Outpatient Visits</i>	90% per visit after the Calendar Year deductible	90% per visit after the Calendar Year deductible	90% per visit after the Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Infertility Treatment</i>			
<i>Basic Infertility Expenses</i> Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Inpatient Treatment of Mental Disorders</i>			

<i>MENTAL DISORDERS</i>			
<i>Hospital Facility Expenses</i>			
Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Physician Services	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible

Inpatient Residential Treatment

Facility Expenses	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Physician Services	80% after Calendar Year deductible	60% after Calendar Year deductible	80% after Calendar Year deductible

Outpatient Treatment Of Mental Disorders

<i>Outpatient Services</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
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Inpatient Treatment of Substance Abuse***Hospital Facility Expense***

Room and Board	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Other than Room and Board	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Physician Services	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible

Inpatient Residential Treatment

Facility Expenses	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible	80% per admission after Calendar Year deductible
Physician Services	80% after Calendar Year deductible	80% after Calendar Year deductible	80% after Calendar Year deductible

Outpatient Treatment of Substance Abuse

<i>Outpatient Treatment</i>	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
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PLAN FEATURES	NETWORK Institute of Quality (IOQ) Facility	NETWORK Non-IOQ Facility	OUT-OF-NETWORK
<i>Obesity Treatment Non Surgical</i>			
<i>Outpatient Obesity Treatment (non surgical)</i>	80% per visit after Calendar Year deductible	Not Covered	Not Covered

PLAN FEATURES	NETWORK Institute of Quality (IOQ) Facility	NETWORK Non-IOQ Facility	OUT-OF-NETWORK
<i>Obesity Treatment Surgical</i>			
<i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</i>	80% per admission No Calendar Year deductible applies	Not Covered	Not Covered
<i>Outpatient Morbid Obesity Surgery</i>	80% per service after Calendar Year deductible	Not Covered	Not Covered

Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Not Covered	Not Covered
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PLAN FEATURES	NETWORK Institute of Excellence (IOE) Facility	NETWORK Non-IOE Facility	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Transplant Services Facility and Non-Facility Expenses</i>				
<i>Transplant Facility Expenses</i>	80% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
<i>Transplant Physician Services</i> (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided	Payable in accordance with the type of expense incurred and the place where service is provided

PLAN FEATURES

Other Covered Health Expenses

<i>Acupuncture</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Maximum visits per Calendar year (excluding treatment of substance abuse)	12	12	12
Blood Bank Charges	80% after Calendar Year deductible	80% after Calendar Year deductible	80% after Calendar Year deductible
<i>Clinical Trial Therapies</i> (Experimental or Investigational Treatment)	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Routine Patient Costs</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Ground, Air or Water Ambulance</i>	80% after Calendar Year deductible	80% after Calendar Year deductible	80% after Calendar Year deductible
<i>Diabetic Equipment, Supplies and Education</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Durable Medical and Surgical Equipment</i>	80% per item after Calendar Year deductible	80% per item after Calendar Year deductible	80% per item after Calendar Year deductible

<i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i>			
Orthodontic treatment directly related to an orthognathic surgical procedure	80% of billed charges after Calendar Year deductible	80% of billed charges after Calendar Year deductible	80% of billed charges after Calendar Year deductible
All other treatment	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
Orthodontic treatment directly related to an orthognathic surgical procedure Lifetime Maximum	\$10,000	\$10,000	\$10,000
Accidental injury treatment Maximum Benefit	\$600 per occurrence	\$600 per occurrence	\$600 per occurrence
Phenylketonuria Formula	100% after Calendar Year deductible	100% after Calendar Year deductible	100% after Calendar Year deductible
<i>Prosthetic Devices</i>	80% per item after Calendar Year deductible	60% per item after Calendar Year deductible	80% per item after Calendar Year deductible
Foot Orthotics Lifetime Maximum Benefit	\$500	\$500	\$500
Transgender Reassignment (Sex Change) Surgery	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Outpatient Therapies</i>			
<i>Chemotherapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Infusion Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Radiation Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Short Term Outpatient Rehabilitation Therapies</i>			
<i>Outpatient Physical, Massage, Occupational, Speech, Cardiac and Pulmonary Therapy</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
Combined Physical, Massage, Occupational, Speech, Cardiac and Pulmonary Therapy Maximum visits per Calendar Year	35 visits	35 visits	35 visits

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Neurodevelopmental Therapy</i>			
<i>Outpatient Neurodevelopmental Therapy*</i>	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

* Benefits for rehabilitation therapy may not be duplicated for the same conditions and services.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Spinal Manipulation</i>			
<i>Spinal Manipulation</i>	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

Spinal Manipulation Maximum visits per Calendar Year	10 visits	10 visits	10 visits
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Autism Spectrum Disorder</i>			
<i>Autism - Behavioral therapy</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible
<i>Autism - Applied Behavior Analysis</i>	80% per visit after Calendar Year deductible	60% per visit after Calendar Year deductible	80% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK	OTHER HEALTH CARE
<i>Habilitative Services</i>			
Therapy for Children with Developmental Delays	80% after Calendar Year deductible	60% after Calendar Year deductible	80% after Calendar Year deductible

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK	OUT-OF-NETWORK
<i>Preferred Generic Prescription Drugs</i>		
For each 34 day supply* filled at a retail pharmacy	\$5	Not Covered
For all fills of at least a 35 day supply and up to a 90 day supply filled at a mail order pharmacy	\$10	Not Covered
<i>Preferred Brand-Name Prescription Drugs</i>		
For each 34 day supply* (retail)	\$10	Not Covered
For more than a 34 day supply but less than a 91 day supply (mail order)	\$20	Not Covered
<i>Non-Preferred Generic Prescription Drugs</i>		
For each 34 day supply* (retail)	\$5	Not Covered
For more than a 34 day supply but less than a 91 day supply (mail order)	\$10	Not Covered
<i>Non-Preferred Brand-Name Prescription Drugs</i>		
For each 34 day supply* filled at a retail pharmacy	\$25	Not Covered
For all fills of at least a 35 day supply and up to a 90 day supply filled at a mail order pharmacy	\$50	Not Covered
<i>Smoking Cessation Aids or Drugs</i>		
Smoking Cessation Aids or Drugs Lifetime Maximum Benefit	One 90 day supply	Not Covered

* The greater of 34 day supply or 100 unit doses for generic prescription drugs on Aetna's maintenance drug list.

Coinsurance

	NETWORK	OUT-OF-NETWORK
<i>Prescription Drug Plan Coinsurance</i>	100% of the negotiated charge	Not Covered

The **prescription drug plan coinsurance** is the percentage of **prescription drug covered expenses** that the plan pays after any applicable **deductibles** and **copays** have been met.

Prescription Drug Maximum Out-of-Pocket Limit (Annual Limit)

	NETWORK	OUT-OF-NETWORK
<i>Prescription Drug Maximum Out-of-Pocket Limit</i>	\$1,200 Individual \$3,600 Family	Not Covered Not Covered

Individual Prescription Drug Maximum Out-of-Pocket Limit: Your plan has limitations set for what you are expected to contribute. Your plan will pay benefits for **prescription drug covered expenses**, as follows:

Prescription Drug Maximum Out-of-Pocket Limit

When your share or each of your covered dependent's share of **prescription drug covered expenses** reach the **prescription drug Maximum Out-of-Pocket Limit** in a calendar year, your plan will pay 100% of that person's **prescription drug covered expenses** for the rest of the calendar year. The **prescription drug Maximum Out-of-Pocket Limit** applies to **network** and **out-of-network prescription drug covered expenses** combined.

Family Prescription Drug Maximum Out-of-Pocket Limit. Your plan has limitations set for what your family is expected to contribute. Your plan will pay benefits for **covered expenses** as follows:

Prescription Drug Maximum Out-of-Pocket Limit

When your share and your covered dependents share of **prescription drug covered expenses** combined reach the family **prescription drug Maximum Out-of-Pocket Limit** in a calendar year, your plan will pay 100% of the family's **covered expenses** for the rest of the calendar year. The family **prescription drug Maximum Out-of-Pocket Limit** applies to **network** and **out-of-network prescription drug covered expenses** combined.

Excluded Covered Expenses

Certain **prescription drug covered expenses** do not apply toward your individual **prescription drug** out-of-pocket limit and the family prescription **drug** out-of-pocket limit. These include:

Expenses above the **recognized charge**.

Non-covered expenses.

Expense Provisions

The following provisions apply to your health expense plan.

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

Covered expenses applied to the **out-of-network provider deductibles** will be applied to satisfy the **network provider deductibles**. Covered expenses applied to the **network provider deductibles** will be applied to satisfy the **out-of-network provider deductibles**.

All **covered expenses** accumulate toward the **network provider and out-of-network provider deductibles** except for those **covered expenses** identified later in this *Schedule of Benefits*.

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

Network Provider and Other Health Care Calendar Year Deductible

Individual

This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from a **network provider** and for **other health care** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur from a **network provider** and for **other health care** for the rest of the Calendar Year.

Family Deductible Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles**, these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Out-of-Network Provider Calendar Year Deductible

Individual

This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from an **out-of-network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**, this Plan will begin to pay benefits for **covered expenses** that you incur from an **out-of-network provider** for the rest of the Calendar Year.

Family Deductible Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles**, these expenses will also count toward a family **deductible** limit.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

The combined **covered expenses** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Common Accident Out-of-Network Deductible Limit

This limit applies when two or more family members are injured in the same accident. The common accident **out-of-network deductible** limit places a limit on your **deductible** expenses when **covered expenses** are applied toward the separate Calendar Year **deductibles** for **out-of-network providers** and for **other health care**. When this occurs, and all **covered expenses** related to the accident in that Calendar Year exceed the common accident **out-of-network deductible** limit, your plan will then pay the excess amount based on the plan **payment** percentage. The added benefit will be reduced by any family **out-of-network deductible** limit benefit amount paid for the same **covered expenses**.

Deductible Carryover

Under this feature, any **covered expenses** that you incur in the last three months of a Calendar Year that apply toward that year's Calendar Year **deductibles** for **network providers**, **out-of-network providers** and **other health care** will also count toward the following year's **network providers**, **out-of-network providers** and **other health care deductibles**.

Copayments and Benefit Deductible Provisions

Copayment, Copay

This is a specified dollar amount or percentage, shown in the *Schedule of Benefits*, you are required to pay for **covered expenses**.

Payment Provisions

Payment Percentage

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "Plan Payment Percentage". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

Payment Limit

The **Payment** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. This Plan has an individual **Payment Limit**. As to the individual **Payment Limit**, each of you must meet your **Payment Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Payment Limit**. See list below.

Network Provider and Other Health Care Payment Limit

Individual

Once the amount of eligible **network provider** and **other health care** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Payment Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Out-of-Network Provider Payment Limit

Individual

Once the amount of eligible **out-of-network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Payment Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

The **Payment Limit** applies to both network and out-of-network benefits. **Covered expenses** applied to the out-of-network **Payment Limit** will be applied to satisfy the in-network **Payment Limit** and **covered expenses** applied to the in-network **Payment Limit** will be applied to satisfy the out-of-network **Payment Limit**.

Expenses That Do Not Apply to Your Payment Limit

Certain covered expenses do not apply toward your plan payment limit. These include:

- Charges over the **recognized charge**;
- Expenses applied toward a **copayment**;
- Expenses incurred for outpatient **prescription drugs**;
- Expenses incurred for short-term outpatient rehabilitation therapy and neurodevelopmental therapy expenses;
- Non-covered expenses; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

Maximum Benefit Provisions

Lifetime Maximum Benefit

The most the plan will pay for covered expenses incurred by any one covered person during their lifetime is called the Lifetime Maximum Benefit.

The Lifetime Maximum Benefit applies to **network** and **out-of-network** expenses combined.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.